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Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England

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Abstract: Politics around sexual health have been polarised in recent years, but the policy implications of this polarisation have not yet been examined in depth. Therefore, this article explores political challenges to a rights-based approach in sexual health policies in Turkey and England. Its focus is on two domains: The prevention and treatment of sexually transmitted infections (STI), and sexual health education. Drawing on an interpretive documentary analysis, this article reveals that although social attitudes to sexuality and the levels of overall alignment with a rights-based framework within the selected countries do differ, both face significant political challenges in putting a rights-based approach to sexual health into practice. While common political challenges include heightened domestic controversy regarding sexual health, the specific challenges take the forms of a broader conservative turn that undermines the autonomy of sexual health policy in Turkey (similar to the cases of Hungary and Poland), and neoliberal policy preferences coupled with local discretion and service fragmentation that create access inequities in England (similar to the case of Germany). This study concludes that implementing a rights-based approach is a complex political task requiring a nuanced approach that incorporates the political dimension.

Keywords: England; rights-based approach; sexual citizenship; sexual health; sexual rights; sex education; sex and relationships education (SRE); sexually transmitted infection (STI) prevention; STI treatment; Turkey

1. Introduction

The United Nations (UN) International Conference on Population and Development (ICPD)–held in Cairo in 1994—marked the emergence of a global consensus on the importance of an individual rights-based sexual and reproductive health policy framework. Almost three decades after the emergence of this broad consensus, the international political community is now divided on their support for recognition and promotion of sexual rights [1,2]. This divide may result from political backlash against an increasing recognition of gender equality and a reaction to the introduction of legislation on equality and human rights [3].

Building on previous comparative studies on sexual and reproductive health policies and gender politics [4,5], this article examines the political challenges to putting rights-based sexual health policy framework into practice in Turkey and England in the 2010s. Using Gerring's definition for a most-different case study design [6], we suggest that Turkey and England are different in all respects, except for their inclusion in the same global rights-based sexual and reproductive health policy framework. Turkey and England share a policy legacy, having both been part of the rights-based

sexual health policy development that emerged after the 1994 Cairo conference. In addition, both countries reiterated their commitments to this agenda at the 2019 Nairobi summit [7] and by 2018, they were both among the donor countries to the United Nations Population Fund (UNFPA) [8]. While the United Kingdom's financial contribution to UNFPA was significantly higher than those of comparable countries such as Germany and France, Turkey's contribution—which was similar to Poland's—remained modest [8] yet symbolically important. Shared international policy benchmarks were used as a rationale for cross-country comparison in previous studies [9,10].

Despite sharing the same international policy benchmarks, Turkey and England represent divergent social contexts with respect to attitudes towards sexuality. In a 2013 survey, for example, the following question was asked to a representative sample in both countries: 'Do you personally believe that sex between unmarried adults is morally acceptable, morally unacceptable, or is it not a moral issue?'. While 44% of British respondents reported that consensual sex between unmarried adults is not a moral issue and 38% replied that it is morally acceptable, the overwhelming majority of Turkish respondents (91%) indicated that it is morally unacceptable [11]. The attitudes of the British respondents resembled those of the German and French respondents. Turkish attitudes were contrary to most in the European region—the countries who compared most closely were Russia and Poland [11]. The research of Lefkowitz et al. [12] suggests that both religiosity and secular values are linked to social attitudes towards sexuality. Differences in countries' value systems were documented by the World Values Survey Wave 5 (2005–2009) [13], which ranked countries according to overall secular values. The mean for Turkish respondents was 0.24 (holding more religious values), versus 0.4 (holding more secular values) for respondents in Great Britain (including England). Once again, while British attitudes were close to those of Germany and France, Turkish attitudes were more closely aligned to those of Poland. These dissimilar social attitudes towards sexuality in the selected countries and in the European region may set different parameters for the politics of sexual health policy. While the difference in social attitudes is significant, it should not be seen as unchangeable or as an excuse for cultural relativism, as research in other domains indicates policy changes may give rise to major attitudinal shifts [14,15].

Our cross-national comparison addresses the following question: What political factors limit the full incorporation of a rights-based approach into domestic sexual health policies in these different country cases that share the same international policy benchmarks? Our discussion addresses these challenges in the context of two domains of sexual health policy in the selected countries: (1) The prevention and treatment of STIs, and (2) sexual health education for children and young people. These represent areas of priority and current intervention in sexual health policy.

The central argument for this study is that both countries face significant political challenges to putting a rights-based policy framework into practice. This article suggests that the political challenge that both countries have in common is heightened domestic political controversy regarding sexual health policy. In addition, the broader conservative turn in Turkey (similar to that of Hungary and Poland) undermines the autonomy of sexual health policy and neoliberal policy preferences, while in England, there is the additional challenge of local discretion and service fragmentation creating inequities in access to sexual health services and comprehensive sexual health education (similar to the case of Germany). These political challenges imply that the incorporation of a rights-based approach to sexual health policy remains an incomplete and complex political task in these most-different cases. Such an endeavour, therefore, necessitates a closer look at domestic sexual health politics, and requires a nuanced approach to policymaking and practices incorporating the political dimension.

2. A Rights-Based Approach to Sexual Health Policy

A rights-based approach to sexual health policy is unique, as it puts emphasis on the responsibility of government to not only provide services, but also improve social determinants that influence the sexual health of its citizens [16]. The emergence of a rights-based approach to sexual health policy dates back to the late 1970s. In 1975, almost two decades before the ICPD, the World Health

Organization (WHO) defined the fundamentals for achieving sexual health as follows: 'the right to sexual information and the right to pleasure' [17]. In 2002—during the process of updating its 1975 report—the WHO convened a technical consultation on sexual health, which proposed the following working definition of sexual rights:

> . . . the right of all persons, free of coercion, discrimination, and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive, and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life. [18]

Since the 1990s, calls for sexual rights have been voiced at UN platforms and conferences. The 1994 UN ICPD—held in Cairo—is often cited as a pivotal event, as this was the first time sexual and reproductive rights were acknowledged as fundamental human rights [19]. The conference described reproductive health in terms of people's ability 'to have a satisfying and safe sex life', and declared that all people should have 'the capability to reproduce and the freedom to decide if, when and how often to do so' [19]. The conference introduced a programme of action that has made 'the provision of universal access to reproductive health services, including family planning and sexual health' a global policy target [19]. The ICPD also underlined the relationship between reproductive health and sexual health, asserting that the former includes the latter [19]. While the 1994 UN ICPD refrained from 'creating new international human rights' [19], the application of a rights framework to sexual and reproductive health has been revolutionary in granting autonomy to this policy domain, especially in the context of population and economic development policies and individual empowerment.

The notion of sexual citizenship [20–26] in social theory—introduced in the 1990s—successfully addresses both the civil and social rights dimensions of attaining sexual health. It not only defines the responsibility of the public sector to provide sexual and reproductive health information and services [27], but it also acknowledges the importance of leaving all choices with regard to sexuality and reproduction to empowered individuals. There is a burgeoning discussion of how sexuality—as a socially and politically defined structure—shapes ideas about citizenship, belonging, and recognition [20–26]. The notion of sexual citizenship captures debates and claims 'about belonging, about rights and responsibilities' [25]—alternatively, what Plummer [22] describes as 'intimate citizenship'—pertaining to the rights and responsibilities connected to 'intimate desires, pleasures, and ways of being in the world' [22].

Political dynamics determine whether and to what extent a rights-based approach to sexual health will inform global and domestic policies. On one hand, strides made by feminist activists in transforming the understanding of sexual and reproductive health policy resulted in the consolidation of a global anti-sexual rights alliance, especially in the 2010s. The Vatican, in opposing the ICPD framework, introduced the concept of 'gender ideology' and denounced the idea of gender equality, which they claimed is at odds with the teachings of Catholicism on the complementarity of women and men and their intrinsic differences [28]. The Vatican's specific opposition to the ICPD framework was the recognition of individuals as decision-makers with respect to their sexuality and reproduction. Later, the Vatican condemned the teaching of gender identity in schools as 'ideological colonisation' [29]. Since the beginning of the 2000s, an international coalition that included some post-Soviet, political Islamist and African states, along with faith-based interest groups—such as the New Christian Right in the United States and other well-funded ultra-conservative lobbying groups—started to espouse the Vatican's ideas and began challenging the rights-based sexual and reproductive health framework [30]. The latest manifestation of the power of the anti-sexual rights alliance has been President Trump's decision to halt US financial contributions to UNFPA because of its alleged support for a programme of 'coercive abortion' [31]. On the other hand, the rights-based approach to sexual and reproductive health still influences the global development policy agenda, as evidenced at the 2019 Nairobi summit. In addition, one of the UN's Sustainable Development Goals—an initiative established to set common

targets for all member states—is 'ensuring healthy lives and promotion of well-being for all at all ages' [32]. This goal includes 'ensuring universal access to sexual and reproductive health care services' by 2030 [32].

In this context, examining domestic sexual health policy trends by taking the contemporary politics of sexual health into consideration [33–40] is crucial to an understanding of the contemporary challenges to the realisation of a rights-based approach to sexual health policy, for two reasons. First, the resilience of support for a rights-based sexual health agenda at the global level—coupled with an increasing volume of activity from and the growing power of the anti-sexual rights alliance—is an indication that conflict over sexual health policies will not easily disappear in the near future. Second, as Lottes [41] suggests, comparing countries where a rights-based approach receives higher social and political support (such as England, Germany, and France) with others (such as Hungary, Poland, and Turkey) where it has less support will provide insight into risks and opportunities for the promotion of rights-based sexual health policies in different contexts.

3. Materials and Methods

This article combines a qualitative analysis of within-case policy changes in Turkey and England with an approximation of a most-different case study design. The analysis of policy trends and political challenges in the selected countries was supported by shadow cases (Hungary and Poland for Turkey, and Germany and France for England). This article draws on comprehensive document analysis, a method that is widely used in qualitative case studies [42]. To identify key documents for the analysis, we compiled a full list of key stakeholders in sexual health policies in the selected countries, including relevant public authorities and vocal non-governmental actors on the subject. The following organisations were identified as key stakeholders: Public authorities with mandates to plan, implement, and monitor the prevention and treatment of STIs and sexual health education policies; non-governmental organisations (NGOs) advocating for a rights-based approach to sexual health policy; and faith-based interest groups voicing objections to current and proposed policy directions.

In the case of Turkey, five public authorities—the Ministry of Development (formerly, the State Planning Organisation), the Ministry of Health, the Ministry of Education, the Ministry of Family and Social Policies (currently, the Ministry of Family, Labour, and Social Services), and the municipality of Sisli—one international organisation (UNFPA), and two Turkey-based NGOs (the Turkish Family Health and Planning Foundation and the Community Volunteers Foundation) were included in the list. One ultra-conservative media outlet (Habervaktim) was also added to the list, as it is the most vocal faith-based interest group opposing the rights-based framework in Turkey. In the case of England, six public authorities—the House of Commons, the House of Lords, National Health Services (NHS) England, Public Health England, the National Institute for Health and Care Excellence, and the Department for Education—one professional body (the Royal College of General Practitioners-UK), and three NGOs—the British Association for Sexual Health and HIV (BASHH); the Personal, Social, Health, and Economic Education Association (PSHE Association); and the Christian Institute—were included.

Inclusion criteria for the documents produced by these organisations were broad; to be included, documents must (1) have been published in the 2010s, (2) refer to policies on the prevention and treatment of STIs or sexual health education, and (3) express the position of the relevant stakeholders on sexual health policies in either of the selected countries. Using their websites, we collected a total of 30 documents (15 for each country) produced by these stakeholders. The final list consists of a balanced number of documents both on the selected policy domain and the country case (nine documents per country on the prevention and treatment of STIs and six documents per country on sexual health education). The breakdown of documents is also balanced across different types of stakeholders in the selected cases. Table 1 below illustrates the breakdown of documents analysed.

Table 1. The breakdown of documents analysed.

		STI Prevention & Treatment	Sexual Health Education
Turkey	Public authorities	6	3
	NGOs	3	3
England	Public authorities	5	4
	NGOs	4	2

We relied mainly on an interpretive analysis approach, which treats documents not as mere reflections of the reality, but as partial representations and at times, aspirations, of particular actors [43]. When applied to policy analysis, the interpretive approach puts the agency of political actors, their framings, and their aspirations at the centre of the analysis [44]. The benefit of using an interpretive approach is its ability to bring politics back to policy analysis.

We applied three stages of inductive and interpretive content analysis to these documents. At each stage, we independently identified and coded categories from the documents collected for each country. During the coding process, we met three times to discuss and agree on the categories emerging from the documentary analysis. The first stage detected broad policy trends with respect to sexual health in the selected cases. In the second stage, the contentious issues between public authorities and other stakeholders with respect to sexual health policies were noted. The third stage identified the points of divergence between stakeholder opinions on the contentious issues noted in the second stage, as they were stated by these stakeholders. The last stage of inductive thematic analysis led to the identification of three points of contention: Controversy over (1) the strength of sexual health as an autonomous policy domain in relation to other policies (e.g., population policy and fiscal policy), (2) the content of sexual health services and sex education, and (3) conditions of access to sexual health services and sex education. These points of divergence in the opinions of different stakeholders regarding sexual health policy in both countries are shown in the results section through the discussions of the selected contentious issues (e.g., controversy over condom distribution in public spaces in Turkey and the provision of anti-retroviral drugs to prevent HIV transmission in England).

4. Results

4.1. Sexual Health Policy Directions in Turkey

Turkey has been an outlier in the extended Middle East and North Africa region [45], due to its essentially non-punitive legal framework on sexuality and its history of sexual and reproductive health policy development and practices. While the country established a service capacity for family planning starting from the 1960s, Turkey's adoption of a rights-based approach to sexual and reproductive health dates back to the emergence of the 1994 ICPD framework. Despite the country's continued commitment to the rights-based agenda at the diplomatic level, the official political rhetoric on sexual and reproductive health has changed significantly since the early 2010s.

4.1.1. The Prevention and Treatment of STIs

Pre-1994 ICPD health policy in Turkey focused solely on family planning, framing this policy as part of its population policy serving its national developmentalist economic strategy. The adoption of the ICPD framework, however, led to a new emphasis on women's health [46]. UNFPA, the United States Agency for International Development, the European Union (EU), and the UN International Children's Emergency Fund (UNICEF)—in collaboration with Turkey-based NGOs (including, but not limited to, the Human Resources Development Foundation)—played key roles in extending reproductive health care programmes that emphasised gender equality and the empowerment of women [46].

It is necessary to take a brief look at the sexual health policy landscape in the 2000s in order to contextualise the change in political rhetoric and policies in the early 2010s. In line with the democratic vitality of Turkey in the 2000s, sexual and reproductive health had become an important part of policy agenda, and a rights-based framework gained visibility. The integration of reproductive health and family planning services into primary health care, support for reproductive health throughout the life cycle and without gender-based discrimination, the strengthening of service capacity, and easier access to services were among Turkey's policy priorities in this period [47].

Turkey's reproductive health programme—a collaborative project between the Turkish Ministry of Health and the European Commission—was in effect from 2003 to 2007. This programme built significant capacity in Turkey's health care system for sexual and reproductive health care and offered financial support for NGO activities supporting rights-based sexual health policy promotion. One of the products of this programme was the development of service standards for sexual and reproductive health care [48]. This standards document identified the core components of sexual and reproductive health care as (1) STI prevention, which focused on HIV and sexual and reproductive health care for young people and men, and (2) family planning. The priority groups were listed as follows: Victims of violence (all forms, including sexual violence), people with disabilities, and individuals with 'different sexual orientations' (an inaccurate but symbolically important reference to lesbian, gay, bisexual, and transgender (LGBT) persons) [48]. Finally, Turkey issued a national strategic action plan for sexual and reproductive health for 2005 to 2015 [49].

These policy efforts were brought to a halt in the early 2010s by a policy shift that led to the marginalisation of sexual and reproductive health policies, including family planning. Concurrently, Hungary has also moved away from a rights-based policy framework for sexual health, due to a change in government [50]. The shift in the Turkish government's position can be seen in the 2014–2018 national development plan, which removed references to family planning and sexual and reproductive health and replaced them with two new priorities: Protecting the family and maintaining Turkey's young population demographics [51]. This signifies a fundamental change in policy direction, undermining the autonomy of sexual and reproductive health policy by subjecting it to population policy. Alongside these changes, references to a rights-based approach also disappeared from Turkish policy documents.

Despite the current negative trend in sexual and reproductive health policy described above, there has been no reduction in the universal social insurance benefits package, which provides free STI (including HIV) testing and treatment. STI testing and treatment services proved to be resilient, as evidenced in the publication of Turkey's 2019 HIV/AIDS control programme by the Ministry of Health [52], which promised to strengthen these services. As a result of this political commitment, there are few financial obstacles to diagnostic services and treatment. However, discrimination-related obstacles in accessing such services remain. For instance, the low level of knowledge about HIV infection and a high level of prejudice among medical personnel against people living with HIV (PLHIV) [53] might still be acting as a disincentive for patients to apply for testing or to start and continue treatment. This is an expected outcome, as medical education in Turkey does not cover sexual and reproductive health issues from a rights-based perspective.

Confidential and anonymous STI testing is not available in Turkish hospitals. However, a small number of district municipalities—those in which the main opposition party, the Republican People's Party (CHP), is in power—launched confidential and anonymous STI testing services when the rights-based framework was being challenged at the national policy level. For example, Sisli—a district municipality in Istanbul—has offered confidential anonymous STI testing since 2014 [54]. This service was introduced in response to appeals from LGBT rights organisations [55]. Following Sisli's example, two other CHP-run municipalities—Cankaya and Besiktas, in Ankara and Istanbul, respectively—launched the same service. The different actions towards sexual and reproductive health by the central administration and the municipalities may well be considered a local manifestation of the political polarisation over a rights-based approach to sexual health at the global level.

The STI prevention component has been especially stymied by current policy trends and changes in political rhetoric. Despite the fact that an overwhelming majority of Turkish society has adopted a moralistic attitude to sexuality, the Ministry of Health's distribution of free condoms was welcomed by the mainstream media in the mid-2000s [56]. Condom distribution, however, became a controversial topic in the 2010s. For example, in 2013, a group of sex workers petitioned the UN for free condoms as a response to the Ministry's failure—or unwillingness—to distribute free condoms [57]. The Ministry continued to distribute free condoms in primary health care centres and to send free condoms upon request to human rights NGOs [58]. Since the 2010s, however, the ultra-conservative media have increasingly politicised condom distribution practices [59] by capitalising on the political opportunities offered by the broader conservative turn. The framing by the ultra-conservative media of sexual health promotion campaigns created considerable pressure for both the public sector and NGOs. For example, the CHP-led Mersin Metropolitan Municipality's sexual health promotion campaign on a public university campus came under fire, first by the ultra-conservative media [60], and then by local conservative politicians on the municipal council [61]. While the campaign was a joint venture between the municipality and the Ministry of Health, the Ministry refrained from public support of the campaign. This event is just the latest manifestation of the growing power of the anti-rights alliance between the ultra-conservative media and local politicians.

Turkey's current treatment-centred approach and the increasing pressure on sexual health promotion have failed to tackle the spread of STIs. Although Turkey is still categorised as a low-prevalence country, it is a country that has seen a rapid rise in HIV prevalence over the last decade [52]. Like Turkey, Poland also lacks an integrated STI prevention strategy [62] and implements a treatment-centred approach. The Polish strategy has also led to a failure in controlling the increase in STI prevalence [63]. These negative prevention outcomes provide evidence for the limited effectiveness of an exclusive focus on free STI testing and treatment—for success, these services must be complemented with a strong preventive component and a positive change in the political environment within which these sexual health programmes operate.

4.1.2. Sexual Health Education

It is clear that sexual health education for young people in Turkey is an unmet need. Information on reproductive health as part of the national curriculum is only provided to secondary school students in biology lessons [64], and only very restricted information is offered on the subject of human reproduction. The state of sexual health education in Turkey mirrors the situation in Poland, where sexual health education is also practically non-existent in the national curriculum [65]. As a result of this deficiency, the level of knowledge among Turkish youth regarding sexual and reproductive health issues is limited. According to a 2007 survey of 15- to 24-year-olds, more than 60% of those who had heard of STIs stated that they did not know the symptoms [66]. Results from the same survey indicated that the media—including the internet—was the main source of STI information for young people [66]. However, almost half of the young people interviewed reported that they would prefer to receive information on sexual and reproductive health issues from a medical doctor in either a hospital or a school setting [66]. In a 2013 survey, 41% of adolescents between the ages of 12 and 18 reported that they were unable to find adequate answers to their questions about sexuality [67]. Respondents to this survey stated that they would prefer to receive information about sexuality from their families, or alternatively, from their school [67].

The sexual health education component of Turkey's national curriculum has always been tenuous, but in the early 2000s there were policy-level efforts to introduce sexual health counselling for young people. For example, the Ministry of Health—in collaboration with UNFPA and UNICEF—launched an adolescent and youth health and development programme in 2002, one of the aims of which was to establish youth counselling and health centres nationwide, catering to the 10- to 24-year-old age group. Sixty-seven public and NGO youth counselling and health centres that were established as part of this programme were still active in 2007 [68]. However, uptake of services remained low. Research

on adolescents in 2010 concluded that the low uptake of these services stemmed from several factors: Social pressure regarding adolescent sexuality, a lack of awareness-raising in schools and in families about sexuality and available services, adolescents' worries about being seen by others, and feelings of shame and lack of trust towards providers with respect to confidentiality [69].

In Turkey—and similarly, in Poland—[65] NGOs have always been key players in the promotion of rights-based approach to sexual health through formal and non-formal education. In the early 2000s, the inclusion of sexual and reproductive health in the country's development policy paved the way for fruitful partnerships between the public sector and NGOs in promoting sexual and reproductive health. For example, in 2007, the Sexual Education Treatment and Research Association published an informative report online—entitled 'Youth and Sexuality'—with financial support from the Ministry of Health's EU-funded Reproductive Health Programme. In a context in which sexual health education had been inadequately covered in the school curriculum, such collaborative projects have played key roles in promoting sexual health education and in strengthening the capacity of the public sector to develop a comprehensive sexual health education programme in the future. However, the shift in policy regarding sexual and reproductive health at the national level in the early 2010s has restricted such opportunities for collaboration between NGOs and the public sector. Furthermore, this has undermined the advocacy and operational capacity of NGOs working on sexual health education. Nevertheless, the Turkish policy shift on sexual health education has been less abrupt than that of Poland, where the conservative government has recently turned sex education into a polarising issue in domestic politics with a draft law aimed at criminalising sex education [70].

In the absence of public-sector support since the early 2010s, NGOs in this field have remained active. For example, the Family Health and Planning Foundation—founded in 1985—runs sexual health education programmes for students in primary and secondary schools, as well as training courses for teachers, parents, and health personnel, and a hotline offering sexual health counselling [71]. However, most of this training has taken place in private primary schools [72], so only a small minority of privileged students in Turkey were served. Founded in 2002 with the objective of empowering youth, the Community Volunteers Foundation implemented a peer-training programme for youth sexual and reproductive health in collaboration with UNFPA Turkey. In 2015, approximately 1600 young people—mostly university students—attended these training sessions [73]. New initiatives based primarily in Istanbul and Ankara (e.g., the Association for the Struggle against Sexual Violence and Y-Peer Turkey) have been offering young people—including Syrian refugee youth—sex and relationship education (SRE). Despite the success of the above-mentioned programmes in bringing global knowledge on SRE to the Turkish context, their limited scope means that they struggle to compensate for the lack of comprehensive and rights-based sexual health education for young people.

4.2. Sexual Health Policy Directions in England

England's shift from treating sexual health policy from the perspective of a 'moral framework' to a rights-based approach also coincided with the birth of the 1994 ICPD framework [37], and—unlike in Turkey—this approach has proven to be resilient over the course of the 2010s. In terms of policy direction and service provision, sexual health—including sexual health education—is decentralised and separated across the four UK nations. For this study, we have elected to focus on policy directions in England only. England was selected because it represented the largest population of the four UK nations (estimated to be 56 million), with the fastest rate of population growth [74].

4.2.1. The Prevention and Treatment of STIs

In England, significant changes have been made to the funding, commissioning, and delivery of sexual health services. The 2012 Health and Social Care Act signalled a shift from centrally commissioned services provided by the NHS (at what were referred to as 'GUMs' or genitourinary medicine clinics) to service tenders funded through local authorities legally mandated to provide accessible sexual health services [75]. Commissioning services through localised boards is part of a

wider swing away from hospital-based clinics towards community-based settings, with the rationale that local boards are better placed to identify the sexual health needs of the local population and commission appropriate services.

The tender process opens up a mixed market economy in which sexual health services can be delivered through both NHS and non-NHS providers. This mixed economy arrangement operates parallel to a burgeoning private health sector market, in the midst of a government austerity programme. Recent calls from NGOs—including the BASHH—have raised concerns about UK government cuts to public health budgets that are reducing funding for sexual health services delivered by local authorities [76]. A report from the Royal College of General Practitioners [77] described sexual and reproductive health as being at a tipping point, expressing concerns regarding the risks of fragmented and disparate service commissioning across local communities in the current austerity environment. In Germany, a similar problem of fragmentation in STI testing services was also observed [78].

The English experience shows the insufficiency of strong protections for sexual rights in ensuring effective implementation of STI prevention and treatment policies, unless they are supported with adequate public funding. Recent public health data in England indicates a 5% increase in STI diagnoses between 2017 and 2018 [79]. While transmission rates have fallen, the incidence of HIV diagnosis has continued to rise—especially among gay and bisexual men [80]—despite the focus of England's sexual health policy on widening service access for needs-led groups, including men who have sex with men (MSM). The situations in Germany and France are similar to that of England; despite the fact that both countries have a supportive political environment for rights-based sexual health promotion, significant increases were observed in STI prevalence in Germany [81] and in France [82] in the 2010s.

England's liberal social attitudes towards sexuality, its favourable political climate for rights-based policy implementation, and the increase in STI diagnoses have not neutralised political challenges to the implementation of rights-based sexual health policy. While England does provide access to free condoms [83]—similar to France [84] and different from Germany [85]—efforts to address adverse sexual health outcomes for specific (and often marginalised) populations sit alongside politically and morally charged debates about the public provision and funding of prevention measures. For instance, promoting the well-being and sexual health needs of socially marginalised groups—such as MSM—remains an area of political and institutional debate, as is evidenced in the case of pre-exposure prophylaxis (PrEP). PrEP is an anti-retroviral drug taken in daily doses to prevent HIV transmission among individuals who are at risk of transmission [86]. While the drug has become available through both the German [87] and French [88] health care systems, it is still not available through the NHS in England. Following a review of medical evidence [89], large-scale clinical trials of PrEP commenced in clinics across England in 2016 [90]. The introduction of these trials generated considerable legal debate. In 2016, a parliamentary decision not to fund PrEP through the NHS was overturned in a challenge at the Court of Appeal. The Court of Appeal overruled an earlier High Court ruling that concluded that the NHS was not expected to fund PrEP through local authority public health services [85]. In response, medical researchers leading a four-year trial of PrEP in England have voiced disappointment that this treatment has been subject to a trial rather than immediate specialist provision, despite international studies that substantiate its effectiveness [91]. In 2020, PrEP is still unavailable through routine commissioning, despite a government promise in 2019 that this would be resolved in the coming year [92].

4.2.2. Sexual Health Education

Over the last 20 years, policy on sex education in schools has shifted considerably across England towards a more rights-based approach to education for children and young people. Sexual health education in England has benefited from positive government intervention and multiple iterations of statutory guidance and departmental regulation from varying perspectives and standpoints. In England, sexual health education in schools is currently age-restricted and starts at age 11. English schools have discretion over how and when it is delivered [93]. There are, however, caveats about what can and

cannot be taught. For example, schools are required to cover specific areas, such as reproduction, contraception, and sexual health, but they are cautioned not to promote early sexual activity or determination of sexual orientation.

The introduction of Section 28 in the Local Government Act 1988 explicitly banned the 'promotion' of homosexuality in schools [94], but the ban was lifted in 2003 as a result of extensive campaigning from gay rights groups. Echoes of the Section 28 ban, however, are still present in current government guidance on sex education in schools. Since the introduction of marriage equality [95], teachers are not expected to endorse same-sex marriage, but they are expected to provide factual accounts of the current law. Sexual orientation can be broached in the context of class discussions on homophobia and school bullying, which begs the question of how schools can address homophobic bullying without first discussing sexual orientation and differences. Until the recent change in policy, academies and free schools in England (schools independent from the local education authority) could opt in or out of teaching SRE, suggesting an even greater potential for inconsistency in delivery.

The English government has recently moved, however, to strengthen and expand the delivery of sexual health education in schools by making SRE a statutory requirement for all English schools from September 2019 [96]. This legislative change requires all schools to teach SRE across primary and secondary education [96] by 2020. The news was well received by England's PSHE [97], which described the proposed legislation as a historic step. It has been, however, heavily criticised by faith-based interest groups such as the Christian Institute [98], which maintains that such teaching leads to the 'sexualisation' of children.

A number of conflicting principles are contained within the statutory guidance, which hinders the early implementation of this policy. A key example relates to LGBT lives and relationships: SRE programmes are required to integrate these issues, but parents retain the equal right to withdraw their children from SRE sessions, creating room for children to be opted out of 'sensitive' topics on the grounds of morality and faith differences [99]. Evidence of these conflicting principles was obvious at a local primary school in Birmingham over the course of 2019, where ongoing conflicts have played out between school staff seeking to teach about LGBT lives in their curriculum and the opposing views of protestors from faith-based interest groups. In response, the Department for Education has issued a template letter for parents who wish to withdraw their children from such lessons [100]. Similarly, in Germany, a government-commissioned training booklet on sexual diversity for kindergarten teachers led to street protests in Berlin, bringing together far-right and centre-right politicians [101]. The German practice of imposing fines on parents who refuse to allow their children to attend sex education classes in the context of compulsory sex education was also challenged through both local and international courts. However, in response to parent complaints regarding the refusal of German authorities to exempt their children from compulsory sex education classes, the European Court of Human Rights decided that the German practice is compatible with the principles of pluralism and objectivity [102].

On initial reading, the changes appear to move SRE in English schools towards a more rights-based approach by expanding the current content to recognise different types of relationships (such as friendships and intimate relationships) and to include discussions on well-being, such as mental health and online safety. However, parents would retain the right to withdraw their children from SRE classes, with the exception of lessons on the 'biological aspects of human growth and reproduction', as set out under the Education Act 1996 [103]. The same caveats would be retained for faith-based schools to decide how to align their delivery of sex education with their religious doctrine [96].

5. Discussion

The main limitation of the present study is that it relies on a documentary analysis, which restricts the findings to an interpretation of the content of publicly available documents produced by public authorities, international organisations, professional bodies, NGOs, and faith-based interest groups. In-depth interviews and focus group discussions would allow a better understanding of policy changes in the selected countries—especially for the case of Turkey, where the current political atmosphere may

limit the free expression of rights-based NGOs specialised in sexual health. Further research is needed to refine the findings presented in this article. In addition, the broader applicability of the findings of this study, which relies on an examination of policy trends in most-different cases (namely, Turkey and England) is unknown; further research into other countries is required. While this article does not claim that its findings can be generalised to countries that share similar characteristics with Turkey and England, the secondary literature on countries similar to the selected cases (Hungary and Poland for Turkey, and Germany and France for England) was incorporated to suggest some points of crossover that may inspire further comparative research.

The review of overall sexual health policy directions in Turkey and England demonstrates the different pathways these countries have taken. In Turkey, the nature of policy changes since the early 2010s signals a clear distancing from the rights-based sexual health policy framework that informed policy throughout the 2000s. In contrast, the trend in England has been to harmonise policies with the global framework at the discursive level. Despite this difference in the overall alignment of these countries with the rights-based framework, the review of policy directions in two domains—the prevention and treatment of sexually transmitted infections (STI) and sexual health education—paints a complex picture. The analysis here indicates that neither progress nor hindrance has been linear in these countries. For example, despite the overall positive policy direction in England, a number of significant failures—such as a fragmented support system for PLHIV and the SRE curriculum opt-out option for parents—are observed. Furthermore, despite the broader shift away from a rights-based approach to sexual health in Turkey, STI testing and treatment services as part of universal social insurance proved to be resilient.

This article set out to critically examine political challenges to the full incorporation of a rights-based approach to domestic sexual health policies, with Turkey and England as the selected most-different comparators. Although the selected cases differ in social attitudes to sexuality and their levels of alignment with a rights-based framework, this article demonstrates that sexual health politics pose a common challenge to the implementation of a rights-based approach in both countries. Controversy over sexual health policies in the selected cases is observed in a series of ongoing disagreements and conflicts between different actors about whether to have sexual health as an autonomous policy domain and about the conditions of access to and the content of sexual health services and education. Specific challenges take the form of a broader conservative turn in Turkey—undermining the autonomy of sexual health policy (as in the cases of Hungary and Poland)—and neoliberal policy preferences coupled with local discretion and service fragmentation in England, leading to access inequities (as in the case of Germany).

This study suggests that implementing a rights-based sexual health policy is neither impossible and ungrounded in Turkey, nor smooth and fully supported in England. Domestic politics across these nations play a key role in determining whether, how, and to what extent a rights-based sexual health framework is practised on the ground. In Turkey, sexual health policymaking is more centralised than in England, where sexual health policy has increasingly emphasised localised decision-making by devolved authorities, school administrations, and parents. While Turkey's centralised health governance makes its sexual health policies vulnerable to abrupt and immediate changes—as demonstrated by the conservative political turn that began in the early 2010s—the devolved structure of health and education governance in England potentially leaves its sexual health policies open to local variation and neoliberal governance, leading to access inequities.

The sexual health policy trend in Turkey—similar to those in Hungary and Poland—is towards a shift away from its previous commitment to a rights-based approach. Policy shifts in sexual and reproductive health in Turkey that are examined in this study indicate that the country has increasingly diverged from the positive trend that democratisation generated in the 2000s. As a result, Turkey—alongside Hungary and Poland—is one of the three European countries that decided not to participate in the WHO Action Plan for Sexual and Reproductive Health on the 2030 Agenda for Sustainable Development in Europe [104]. While the policy developments of the 2000s did not

disappear suddenly, public-sector ownership of these developments has declined dramatically. Shifts in dominant political rhetoric and policy in Turkey, for example, have resulted in a failure to implement effective preventive measures to slow the spread of STIs, as well as the abandonment of large-scale initiatives to make comprehensive sexual health education accessible to all young people. In all three of these countries, sexual health promotion has become a politically risky endeavour. Despite both Hungary and Poland being EU member states—where Turkey is only a candidate—developments in these countries may indicate that the EU does not seem to function as an effective supranational platform to ensure member states' compliance with a rights-based sexual health framework, and therefore, it also struggles to play an effective role in promoting a rights-based approach to sexual health policy in Turkey.

In contrast, England has taken positive—albeit hesitant—steps to put rights-based sexual health policies into practice. Despite England's positive policy direction—which is similar to that of Germany and France—STI prevalence continues to increase. Increases in STI prevalence in England, however, did not automatically lead to easier access to prevention. For instance, while PrEP has been available through German and French health care systems, its introduction in the English system did not come without judicial debate and an initial refusal by NHS England. Furthermore, in England, a neoliberal creep towards a mixed economy of health care delivery and the opening up of prevention and treatment services to private providers in the context of austerity could potentially undermine the movement towards a rights-based approach to sexual health policy. Similar to the case in England, a significant increase in STI prevalence in Germany has not yet resulted in easier access to STI testing—especially for those who are not showing any symptoms—or in any policy attempts at reducing fragmentation in STI testing services across the country.

The content of sex education has become much more inclusive and comprehensive in England, although this rights-based pathway to sexual health policy remains uneven and sometimes rocky. There are, however, notable gaps and fissures in policies, which hinder full recognition of a rights-based approach in English policy. While sexual health education became a statutory requirement in England in 2020, parents still retain the right to withdraw their children from all or some of these classes, which is not the case in Germany. While faith-based interest groups challenge the implementation of sexual health education in both England and Germany, their policy responses are different. The former grants an opt-out option for parents, whereas the latter makes no compromises.

This study demonstrates that translating a rights-based policy framework for sexual health into practice is a complex political task, even in countries where rights-based approaches receive higher social and political support. A nuanced approach to challenges to a rights-based approach will be helpful in developing a better understanding of varied sexual health policy directions in the context of complex sexual health politics in different countries. For example, while England's overall policy direction has been towards compliance with a rights-based framework, its health and education governance structure may erode government responsibilities by transferring them to local and parental discretion. Such a transfer results in fragmented service delivery and imbalances in resource allocation across local communities and makes it possible to bypass the nationwide rights-based framework for sex education. The Turkish experience demonstrates that in the context of the central government distancing itself from the rights-based framework, universal social insurance coverage for STI testing and treatment services can endure; municipalities and NGOs can also assume responsibility. However, their invaluable efforts in offering a much-needed alternative do not suffice to compensate for the lack of a nationwide policy commitment. Finally, the Turkish case also shows that the undue influence of ultra-conservative actors on mainstream politics and health care policy implementation deserves special attention if a better understanding of contentious sexual health politics is sought.

6. Conclusions

This article reveals the universal—if context-sensitive—significance of the political dimension in sexual health policymaking and implementation. Political contestations over sexual health continue

within the selected countries, despite the differences between their overall social attitudes to sexuality and their current levels of alignment with a rights-based approach to sexual health. Increasing global division on issues that surround sexual health is echoed in domestic politics in both cases, however the strength and the specific form of these echoes differ. The analysis here reveals a common, but varied, failure of the selected countries to put a rights-based sexual health policy framework fully into practice. While the main specific challenge in Turkey (similar those in Hungary and Poland) is the broader conservative turn and its impact on policymaking, implementation, and civil society activities on rights-based sexual health promotion, England's (and Germany's) main challenge is neoliberal policy preferences and greater local discretion in policy implementation. Researchers should closely follow these articulations of local, national, and international politics regarding sexual health and sexual rights, not only to understand contemporary domestic policy changes in individual countries, but also to examine their potential implications for the continued viability of a rights-based sexual health agenda at the global level.

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